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Delivering alcohol IBA: Is there a case for mainstreaming?

Insights from an expert workshop and from the published literature

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Introduction

Identification and brief advice (IBA) has been widely advocated as a cost effective intervention to address problem drinking. In its classic form, it involves screening, using a validated tool such as the AUDIT (Saunders et al., 1993), followed by a short, structured conversation designed to motivate the individual to change drinking behaviour. Evidence for the effectiveness of IBA comes largely from primary care studies. Research in pharmacies, educational settings and criminal justice settings has indicated the possibilities for successful delivery of IBA but there is little solid evidence to support mainstreaming IBA beyond core medical facilities. Furthermore, even in primary health care settings there are continuing difficulties around implementing IBA (see: Thom et al., 2014) and continuing debate about the research findings (Heather, 2014).

A number of key questions around the drive towards wider implementation of IBA were debated at an expert workshop in Birmingham in November 2014:

1. *What are the challenges and barriers to broadening the contexts in which alcohol IBA is delivered?*
2. *How can these challenges and barriers be addressed?*
3. *Should delivery of alcohol IBA in wider contexts (mainstreaming) be a policy goal?*

The workshop was chaired by Professor Nick Heather, a member of the project advisory group, representing the project funder, Alcohol Research UK. The 18 participants included researchers, trainers, practitioners and policy makers. Short presentations led the discussion (see Appendix 1). The proceedings were recorded and transcribed with agreement from participants.

A number of important themes and findings emerged from the workshop, some of which confirmed conclusions from other research. This short report brings together key insights from existing research and from ideas debated during the workshop. It also draws on findings from a larger on-going study on IBA delivery and training¹. We begin by reflecting on understanding of IBA as an approach and draw attention to the diversity of interpretations and

variations in delivery found in practice. We move on to consider issues which arise when attempting to widen IBA delivery to settings beyond core health care services and look especially at perceptions of role legitimacy and role relevance. Consideration of barriers to delivery lead on to discussion of real world experiences of delivering IBA in different contexts and of the need for thorough preparatory action before introducing IBA into different professional sectors and work settings. Finally, we broach the thorny question of whether it is a good idea to try to 'mainstream' IBA delivery into broader contexts and the ethical dilemmas which emerge in trying to do so.

We acknowledge the important contribution of workshop participants to the report, but the selection and interpretation of information and any conclusions drawn are the responsibility of the authors. All quotations from workshop participants were seen and agreed by them.

IBA and its components

Following identification, 'brief advice' is generally considered to entail structured advice lasting 5-10 minutes. This can be, and commonly is, delivered by non-alcohol specialists. The approach has been shown to be effective for increasing or higher-risk drinkers, but dependent drinkers are normally excluded from studies of IBA. It is to be distinguished from 'extended' brief interventions which are essentially 'brief motivational interviewing' approaches, sometimes referred to as 'brief lifestyle counselling'. Like brief advice, it is delivered in one session but lasts 20-30 minutes and training is needed for those who deliver the intervention. 'Brief motivational interviewing' may involve one or more follow up sessions (Rollnick, Heather & Bell, 1992).

Over the course of the workshop, it became clear that, in practice, the distinction between these approaches is frequently blurred. Workshop participants spoke about 'brief advice' and 'brief interventions' interchangeably, with the term 'intervention' including both very brief advice and extended brief interventions. In short, 'brief interventions' tends to be used as an 'umbrella term' encompassing a spectrum of different approaches. In Scotland, the term normally

used is Alcohol Brief Interventions – ABI - and it was seen as important to distinguish between IBA – regarded as a more rigid, standardised approach which was not particularly 'person centred' - from ABI, which was described as more flexible, allowing greater freedom in the design and implementation of the intervention. In this report, IBA is used as a shorthand to include ABI unless referring specifically to the Scottish programme.

The discussion highlighted the need for future exploration of the key components of IBA / 'brief intervention' approaches. Identifying the active ingredients in IBA becomes especially important when moving away from traditional IBA towards IBA 'light' (which is generally necessary outside health care settings). Some studies have found different components of brief intervention approaches to be effective or 'active' ingredients. In a study examining behaviour change techniques used in brief interventions, Michie et al. (2012) found that promoting self monitoring was associated with improved effectiveness of brief interventions. Other evidence indicates the use of personalised feedback as an effective component (Gaume et al., 2014), but further research is needed to clarify concepts and their interaction with other elements of the intervention. What constitutes appropriate and effective personalised feedback may require teasing out the active ingredient for each individual, so that the concept of 'person centred' IBA comes into play. The question then becomes: which components are effective in which contexts and under which delivery conditions?

...knowing in what context that personalised feedback is being provided and what else is being provided in the same conversation and how that fits with how everybody works in different settings, I think is really key. (workshop participant).

There may be a constellation of behaviour change techniques that produce more effective results in brief intervention approaches but further research is needed to identify optimal combinations.

Delivering IBA in different settings: role legitimacy and role relevance

Overcoming problems of role legitimacy, role adequacy and role support², which act as barriers to delivering IBA in primary health care

settings, have been acknowledged since the classic work of Shaw and colleagues (1978) in the 1970s. There is some indication of improvement in role legitimacy among primary care workers (Wilson et al., 2011) but the issues are still highly relevant when considering a broader base of IBA delivery. Several examples from research and projects conducted by workshop participants were provided.

For instance, low intensity mental health workers were reported to feel strongly that alcohol was not part of their role. One important reason was that, "it was just very much an add-on to what they were expected to be doing anyway" (workshop participant). They felt inadequately trained and they did not feel comfortable with the screening tools or the delivery of brief advice. The value of adopting a flexible approach to IBA delivery was emphasised in a study of eight youth work projects in Scotland. It was necessary to accept a very flexible, very much adapted form of alcohol brief interventions that the staff felt fitted with how they already worked: 'ABIs appeared more likely to be embraced where they were perceived by project staff to be compatible with existing goals and ways of working' (Stead et al., 2014: iv). In one project, the team "were more comfortable with client-led, opportunistic conversations.... ABIs appeared to involve naturalistic conversations around alcohol.... were not well-specified, and tended not to include screening..." (Stead et al. 2014:17). In such settings, the use of formal screening tools and structured intervention approaches was particularly difficult. For instance, what kind of identification and intervention is feasible when the interaction takes place between a youth worker and a young person at the edge of a football field? The projects also highlighted the importance of acceptability to the recipients, of the need to consider whether recipients feel it is legitimate for the worker to ask about alcohol, and of whether the approach adopted is experienced as acceptable (Stead et al. 2014).

Thus, a major factor in delivering IBA in wider contexts is *role relevance* - the extent to which the approach is seen as a relevant part of a particular interaction within a particular context. This issue arises with most groups outside health workers - groups such as the police, the fire service, youth workers and social workers, among others. Consideration of role relevance highlights the problems that can arise if

'mainstreaming' means parachuting a fixed ideal of what identification and brief advice is into a new setting. Standard screening tools may not be appropriate and standardised delivery approaches may not be feasible or appropriate. This returns to the question of what is IBA, how should it be delivered in different settings and how much flexibility is possible before the intervention ceases to be IBA?

Mainstreaming implementation of IBA

What is meant by 'mainstreaming' IBA? Dictionary definitions suggest that it means finding ways to make IBA acceptable to the majority of people, fitting IBA into the values and beliefs of the society, and making it part of everyday practice. This might be achieved in numerous ways although it is likely that a multi-faceted strategy would be needed to overcome current barriers to implementation. A number of possibilities are addressed briefly below.

Include alcohol/ alcohol IBA in wider agendas

A 'Health in All Policy' (HiAP) approach has become increasingly accepted as important at national, European and global levels (Stahl et al. eds., 2006; Commission of the European Communities, 2007). This approach acknowledges that the health sector alone is unable to address the many factors which impact on the health of populations and that the structure and functioning of health care systems is largely at the mercy of political decisions coming, most often, from outside health.

The HiAP approach is to take into account the health impacts of other policies when planning policies, deciding between various policy options and implementing policies in other sectors. The ultimate aim is to create evidence-based policy-making by assessing and discussing the possible health impacts of existing policies as well as proposed policy alternatives. (Ollila et al., 2006: 270-271)

At the broadest level, a HiAP approach would mean that lifestyle factors, including alcohol consumption, would be considered alongside other health determinants across policy domains and within policy formulation at any

level. Health, and consideration of the determinants of health, would be on the agenda when formulating and evaluating agricultural, transport, criminal justice, economic and fiscal policy and so on. Inclusion of alcohol issues as part of a HiAP approach could provide a supportive framework for more specific integration of alcohol interventions including IBA.

At the more strategic level, the UK has been moving, in principle at least, towards a vision of integrated health care which crosses organisational and professional boundaries. This opens opportunities for alcohol interventions to be delivered in many different contexts. Workshop participants mentioned 'making every contact count' (MECC) as one example. MECC is an approach to improving health and reducing health inequalities developed by the NHS and local government (Local Government Association, 2014; NHS Yorkshire and The Humber, 2010)³. It entails encouraging positive, long-term behaviour change and requires organisations to build a culture and operating environment that supports continuous health improvement through every contact with individuals. Clearly, since alcohol is only one determinant of health and IBA is one specific intervention approach, inclusion within the MECC agenda does not necessarily follow. Thus although MECC offers a window of opportunity, integrating interventions such as IBA requires careful consideration of how the alcohol intervention fits into the MECC agenda and what tensions may arise in different delivery contexts:

.... out there people are just delivering stuff, sometimes it's quite purist IBA I think and other times it's whatever fits at the time. How do we get a grip with that and how can we inform what MECC is doing and at least get them to describe accurately what is being delivered in the name of alcohol IBA because it's different everywhere? (workshop participant)

Other relevant agendas were noted as also offering frameworks for encouraging IBA delivery. These included The Workplace Health and Wellbeing Charter⁴ and the NHS Health Check through which three million people a year are invited to have a health check which includes an alcohol screen and, if the result is positive, they are offered brief advice (Public Health England, 2013).

While these developments offer possibilities for identifying people who might benefit from brief advice about alcohol use, there is no guarantee that this will happen and when it does, there is little information about the delivery process and about what is delivered. Assuming that integration of alcohol issues within wider agendas and health strategies will be a continuing trend, better understanding and knowledge about how this works – for whom and in which contexts – is crucial.

Introduce a national programme with targets

In Scotland delivery of ABIs was a significant component of the Scottish Government Alcohol Strategy (2008). A new health improvement target specified a target number of ABIs to be delivered across three priority settings, primary care, accident and emergency and antenatal care. The aim was to achieve embedding of ABI delivery into the core business of the three settings. It was seen as a 'population-wide approach' that would act as 'an effective and essential mechanism for preventing stigma associated with receiving an alcohol intervention' (Parkes et al., 2011: iii). An organisational infrastructure was put in place to support implementation; this comprised: financial support, staff training, a national ABI co-ordinator, a delivery support team and national events. The evaluation found that targets were reached, with the three-year target of 149,449 ABIs delivered ahead of schedule by 2011. The estimated cost of delivering the reported ABI's was approximately £4.4 - £6.3 million (Parkes et al., 2011). Common features which appeared to support implementation included: nationally co-ordinated and locally supported training opportunities; 'leaders' at national to local levels able to support training opportunities and encourage implementation (Parkes et al., 2011; Fitzgerald et al., 2015a).

From 2012, wider settings were included to a lesser extent: criminal justice, social work, housing, homeless and young people's services, partly in the hope of reaching groups which may not easily be accessed in more traditional settings (Parkes et al., 2011:15). An evaluation of 10 projects, all but one delivered to young people in touch with health and advice centres and various youth projects, showed that there was potential for ABI to be delivered in youth settings and that, in general, they were well

received by young people. Facilitating factors identified by project staff and young people from the youth projects included: ensuring coherence between ABIs and existing practice - which entailed adapting the ABI model away from what was seen as a 'medical model', adopting a 'systems approach' which meant working with multi-agency partners, the perception that ABI delivery helped the project to meet its goals, and employment of trained staff with appropriate skills (Stead et al., 2014). The need for flexibility had been noted even in respect to more clinical health settings. In A&E, for example, Parkes et al. (2011: 48) reported the need for, "light touch, context-appropriate and evidence informed models". The wider applicability of these findings was confirmed in a study by Fitzgerald et al. (2015a) which was based on telephone interviews with 14 senior implementation leaders, largely medically trained, working outside general practice in other health and non-health settings. This study also highlighted the importance of adapting both the form and the delivery approach of ABI to be compatible with current practice, as well as the need for flexible training approaches.

Evaluations of the Scottish programme also noted the difficulties and barriers to widening ABI within more traditional settings and beyond. In common with other health programme evaluations and with findings from research on partnership approaches (Thom et al., 2013; Toner et al., 2014; Hunter and Perkins, 2014), issues of responsibility, accountability and ownership were sometimes unclear, the evidence for the intervention was not always agreed, and it was difficult to secure support at a high level (Fitzgerald et al., 2015a).

A key issue in funding a national level programme is whether to set national targets and how to monitor these. In line with the findings from evaluations of other national level programmes to address alcohol-related harm (e.g. Toner et al., 2014), setting national targets has advantages and disadvantages, not least because there are often 'mixed perspectives on the appropriateness of targets as a means of driving policy and practice forward' and the danger that "a programme becomes a 'numbers exercise' " (Stead, 2014: 14). Evaluations of the Scottish programme found that a mandatory programme with national targets was important in securing implementation. Targets gained attention at a

senior level, at least in part because they were monitored and because funding to support delivery of ABI was dependent on meeting targets (Fitzgerald et al., 2015a). However, as Parkes et al. (2011) note, securing engagement with the monitoring systems is not always successful and recording ABI delivery proved challenging especially where there was reliance on pen and paper methods. Concerns were raised that, for a variety of reasons, ABIs may have been delivered but not recorded and a number of systems-related difficulties were identified. Practitioners were clear that recording had to be simplified if ABI was to be mainstreamed. One workshop participant, working with non-health projects, agreed, commenting in personal communication after the workshop that, *"In our area we have data arriving at us in multiple formats"*. Given the problems in more traditional health settings, it is not surprising that data collection and monitoring have been found to pose considerable challenges in less conventional delivery contexts. Stead et al. (2014:45) reported that:

A number of staff spoke about the importance of negotiating required data with fundersSome project staff believed the NHS approach to data collection was too structured and prescriptive, and failed to take adequate account of the way project staff worked with young people.

One important aspect of linking data collection to work context was that conversations tended to go unrecorded if they were not considered to be formal ABIs, for instance if they were conversations taking place during sporting activities or other youth activities, – bringing us back to the issue of 'what is an ABI?'

Finally, evaluations of the Scottish programme emphasise the need to allow sufficient lead-in time to develop a supportive infrastructure prior to implementation. As Stead (2014: 45) commented,

There is a need for sufficient time for programme infrastructures to be developed before expecting evidence of performance. A developmental year should be included to allow time for guidance to be issued, and systems and supports to be developed, prior to expectations of delivery.

Indeed, both the Scottish programme (Parkes et al., 2011:22) and evidence from elsewhere

(Thom et al., 2013) suggest that where a health board or local authority has a history of involvement in alcohol-related work, there is more likely to be a positive response to adopting new initiatives because, to some extent, the ground has already been prepared.

To what extent can the Scottish national programme provide a model for implementation elsewhere? Should IBA be made a compulsory part of at least some professional roles and should there be national targets? While the Scottish example provides some support for a national programme, it also highlights the challenges and indicates the need to ensure that a large-scale (and expensive) project of that nature should be preceded by preparatory work to set up and develop appropriate infrastructures and systems for delivery. It is also worth noting that the evaluations have looked at *reported* ABI delivery without widespread attempt to quality check the fidelity of interventions. Clearly, the experience of the Scottish programme highlights the tensions between intervention fidelity and the need to adapt interventions to be acceptable and practical in different contexts.

Reframe the issues

Even in primary health care settings, many workers consider that dependence (or alcoholism) is what they should address and that any kind of conversation around alcohol should be directed at dependent drinkers. Quotations from studies (see Box 1) illustrate the assumptions underpinning perceptions of the problem and of who is an appropriate target for intervention.

Box 1: Assumptions underpinning perceptions of the problem (from Fitzgerald et al., 2015b and 2011)

'The consensus of the team as a whole is that it's not particularly applicable to our clients.'

'I don't feel I've come across anybody who is drinking more than 6 to 8 units per day.'

'We know what to do if we go in to see a client and they've got alcohol issues, they need to speak to someone about it.'

'I work with foster carers and I hope none of them would have alcohol issues.'

To deliver IBA appropriately, professionals still need to take on board that they should be concerned about people drinking at much lower levels than those with alcohol dependence. Securing a shift in thinking is complicated by the fact that there are often similarities in drinking patterns between those offering advice and the recipients. It was noted, for instance, that GPs are reluctant to tackle people with similar drinking patterns to their own; they don't see it as a problem for themselves. For other GPs, having a similar drinking pattern to their client may pave the way for discussions around drinking (Kaner et al., 2006).

Going beyond the individual professional is the nature of the workplace culture and workplace environment; is it conducive or not conducive to feeling comfortable with delivering these kinds of interventions? An example was given by a workshop participant of an organisation where there was a culture of staff going out to socialise and getting drunk together. In broader settings, issues of individual professionals' own drinking habits and of workplace cultures are likely to arise right across the board as factors in implementation processes and outcomes. Reframing the nature of the problem to be addressed and recognising its fit – or misfit – with the specific occupational group and workplace environment would seem to be a key element in preparing the ground for introducing delivery of IBA.

Secure organizational buy-in

As noted above, there is ample evidence in the literature that securing the backing of senior people is generally seen as necessary for successful adoption of any intervention. One workshop participant voiced the general view:

If you didn't get the senior people in the organisation to also have thought through the role legitimacy issues and to be seen to be leaders, you often get back from the front line staff, 'well I'll do it when I'm told to do it, but unless somebody from above tells me, we won't do it' and that's basically it. (workshop participant).

Furthermore, organisational and managerial support is best seen as part of a 'whole system' approach where the focus of the whole organisation is on finding a non-judgemental way of discussing alcohol and discussing any

issue openly with patients or clients and which builds in coaching and feedback for workers over time; it is also something that is expected within the organisation. Services provided by the Cyrenians for homeless people was given as one example of a 'whole system' organisational approach; the Cyrenians provide a range of prevention, education, residential and social care services along with recovery orientated support for clients with alcohol or drug problems (Dowds and McCluskey, 2011). To reflect back on the meaning of 'mainstreaming' suggested above, it is making IBA acceptable to most people at all levels in the organisation, fitting the intervention into the values and beliefs of the organisation, and making it part of everyday practice.

The consensus that organisational 'buy-in' is a necessary ingredient in offering adequate role support for IBA implementation begs the question of what is 'the organisation'. Very often organisations are groups of smaller agencies with complex administrative structures with multi-layers of accountability, responsibility and decision making powers. Effort is required to identify the appropriate unit for implementation purposes. Do we mean a specific housing agency or a particular youth club or the fire service in X town? Or do we mean the group of agencies within a particular sector – such as the housing sector or the fire service as a whole? The impact and effects of local conditions and issues mean that 'the organisation' might vary according to locality and may not be a universally recognizable unit. The organisational unit of implementation is an issue rarely addressed but important in planning widening IBA delivery into new contexts, especially if a nation-wide roll-out were proposed.

Provide training

Although it is recognised that training can be only a part of the solution, provision of training is frequently proposed as an answer to broadening the base of IBA delivery (see overview of the literature in Thom et al., 2014). The Scottish programme included extensive training and generated a demand for training:

Every service across Scotland, whether they were in the target or weren't in the target, wanted to be trained on alcohol so they could have conversations. There were 120 trainers, ... I don't know how many thousands of practitioners were trained to deliver. There are

loads of non-health practitioners who were asking 'why are we not in the target, why can't we get trained on this, we see lots of people who have alcohol problems, we would like to know more about how to do this'. (workshop participant).

Numerous practical issues relating to the provision of training were noted in the workshop echoing the findings from the literature. These included:

1: Trainers may feel that they have been 'parachuted in' because somebody thought it was a good idea. Delivering standardised training packages is not always appropriate and trainers may need to adapt their approach to take account of trainees' roles and specific work contexts.

2: Trainees may arrive with false expectations about the aims and content of the training.

One participant, responsible for much of the training in one area over a period of time, commented:

Because we've been doing it for years I'm seeing the same people coming back going, hi I did this three years ago. That's great, they are getting a refresher. But the thing that I've noticed is people come on the training thinking it's going to be alcohol awareness, so they are going to get trained and they don't have to do anything at the end of it, they just go away

3: Settings and work contexts can pose problems. In some settings it is difficult to carry out training because the nature of the work – e.g. shift work or very busy environments such as A&E departments – makes it hard to get groups together and multiple short sessions may have to substitute.

4: Issues such as the appropriate content of training, the length of training, the possible effects of altering the training, were described as a 'black box' in terms of delivering training likely to result in implementation of IBA.

There appears to be a substantial amount of alcohol IBA training being delivered across a range of work contexts and to a range of professionals. It is clear that training is provided in different formats and with different content. There is a considerable body of experiential knowledge regarding the many issues which

arise in delivering training in different settings but very little of this knowledge has been captured and capitalised on to increase understanding of how to tackle the 'black box' or to examine and document principles of good practice which would improve the effectiveness of training and support delivery of IBA interventions.

Use on-line systems to widen reach

Studies have reported favourably on the use of online alcohol screening and feedback in student populations and in workplace settings in particular (Thom et al., 2014). One large randomised-controlled trial concluded that, "The trial has indicated a potentially widespread and sustainable demand for Internet based interventions for people with hazardous alcohol consumption" (Wallace et al., 2011). Overall, workshop participants shared a positive view of the potential of on-line systems to access 'hard to reach' groups but they also commented on the drawbacks of the approach mentioning four issues in particular.

First of all, both in the literature and in discussions in the workshop, a major consideration is whether to deliver alcohol IBA as part of a multiple behavioural (or lifestyle) intervention or on its own. Incorporation into a general lifestyle health check may reduce the risks of stigma or concerns about confidentiality – especially if the intervention is accessed via a workplace computer. However, there is a risk that a general lifestyle health check will attract mainly the 'worried well'. This was the finding from one large randomised controlled trial: the tool was accessed by people with very low prevalence of smoking, high levels of physical activity and fruit and veg consumption and with alcohol intake levels comparable to the general population (Khadjesari et al., 2015). Another workshop participant reported that when online IBA was provided to employers as part of an 'alcohol health review' the proportion of increasing/ high risk drinkers was often as high as 60% which may indicate the value of an alcohol specific approach.

A second problem which arises in offering alcohol specific interventions on-line is that brief interventions, by definition, are targeted at non-help seekers, because hazardous and harmful drinkers tend not to seek help with their drinking. However, in the Down your Drink trial⁵, one

workshop participant mentioned how large numbers of people were recruited who were searching for help to reduce their drinking; almost unanimously, they reported a lack of service, both online and in person, suited to their aims to moderate their drinking as opposed to stop drinking altogether, because, they said, all of the services that they were aware of were catering to what they perceived as 'alcoholics'.

Third, in relation to a wider health aim to reduce health inequalities, on-line interventions have been found to fail to reach age groups and socio-economic groups most affected by alcohol; older people and people from routine and manual occupations are disproportionately unrepresented as users of online IBA.

Finally, delivering on-line IBA in workplace settings raised a number of issues. The workplace is extremely important as a potential contact point for population groups unlikely to be picked up in other contexts. The question was raised as to whether on-line IBA should be offered by workplaces as a voluntary self-help resource or whether it should be mandatory for all employees to complete an assessment. The nature of the employment (danger to the public or other workers), the risk that employees will underestimate the amount they drink and problem drinking will not be discovered at an early stage, ethical issues around intrusiveness into personal lives would need to be carefully weighed up in discussing workplace intervention. Even if the intervention is voluntary and workers are promised anonymity, fears that confidentiality would be compromised and that completing online alcohol interventions in the workplace may have career repercussions act as a disincentive (e.g. Watson et al., 2009).

Thus, while there is generally considerable interest in developing self-administered on-line systems and some evidence to suggest that they have a valuable role to play, there are still caveats and unanswered questions which require further examination.

Prepare the ground and put a sound infrastructure in place

The need to conduct meticulous developmental work prior to implementing IBA and to provide evidence relevant to the setting and target group are facets of ensuring that an

appropriate infrastructure is in place to facilitate the delivery of IBA and sustain it in the long term.

Developmental work might entail designing a tool relevant to the setting and acceptable to workers and clients. The example of the Paddington Alcohol Test was given as a tool more suited than other screening instruments for clinicians in A&E settings (Smith et al., 1996). In other settings – for example, in youth work contexts – just asking about alcohol consumption rather than using a formal screening tool may be the appropriate approach (Stead et al., 2013).

As mentioned earlier, there is evidence that screening and brief intervention can be effective but the evidence comes mainly from primary health care studies conducted under optimum (research) conditions rather than in real world situations and there is little assurance that the interventions will be effective in other contexts. In assessing the evidence, Heather (2014:8) argues that:

It is a mistake to go straight to effectiveness trials for new forms of alcohol BI intended for different populations in different settings where the evidence base is thin or nonexistent. The development and testing of new applications of BI should begin with foundational research and developmental studies, followed by efficacy trials, before large-scale effectiveness trials are mounted.

Work to encourage pharmacists to deliver IBA demonstrates such a line of development. Survey studies and focus group work were used to understand the perceptions of service users and pharmacists, whether service users would find it acceptable to talk to a pharmacist about their drinking or not, how pharmacists would like to conduct the discussion, what the content of the conversation should be. They also explored pharmacists' perceptions of their needs for training and how they felt about talking about drinking with customers. From there, feasibility studies were designed and conducted to look at the process of delivering IBA in the pharmacist setting and this study was followed by the first randomized controlled trial (Dhital et al., 2013a; 2013b; 2010).

However, research-based evidence is only one form of knowledge – and one factor – which informs policy making and policy implementation. Although some professions,

notably medical professions, are firmly wedded to the idea of evidence-based practice, for others experience is more important. An example was given by one participant:

my experience is that the lack of evidence isn't a barrier for implementation outside of health settings. It didn't really come up at all in the issue with the youth work training, they weren't particularly bothered, they never really asked about whether there was a study. When we first trained multidisciplinary practitioners GPs were obsessed with the evidence, just like where's the evidence and there was quite a lot of evidence and they still didn't believe it. So we were sort of training these youth workers, social workers, everyone and anyone, job centre staff, police and thinking we are going to be absolutely slated at the end of this. They are going to go why are we here, there is no evidence, what is the point and they never even asked about the evidence, they weren't even bothered. They really were thinking in a different way. I don't think the culture of a lot of professions is necessarily like evidence-based medicine. I think it's much more like does this feel right, does this feel like something that fits with my current practice. (workshop participant).

As well as questioning the importance of having evidence before taking action, there are questions regarding the kind of evidence that might be most useful. For instance, evidence about the 'active ingredients' in IBA may help to design interventions suited to a new setting. In addition, examination of current practice is needed before implementing new approaches in order to show that IBA (or any new approach) would be more effective.

Careful developmental work in different professional contexts could, therefore, address the need for relevant evidence to justify the implementation of IBA in settings beyond traditional health practice.

Increasing acceptability and integrating IBA/ ABI into everyday practice

At the start of this section, we wrote that mainstreaming meant finding ways to make IBA acceptable to the majority of people, fitting IBA into the values and beliefs of the society, and making it part of everyday practice. There is little by way of research evidence to guide implementation. But, there is an accumulating body of practice-based experience and knowledge about what works and does not

work in trying to implement IBA in different contexts. This has rarely been captured or made available in a format accessible to policy makers and service commissioners. The sections above provide a small taster of 'practice based' evidence and offer some insights into how IBA itself may be re-framed to become more integrated into existing professional practice in diverse settings.

Summarising from evidence from the literature and from information given by workshop participants discussed above, a number of basic principles (facilitators) for action may be suggested:

1. Assess the need to adapt IBA to a new context and consider the effects of adaptation on fidelity of the intervention.
2. Assess current practice in the proposed delivery context, recognize that current practice may be closely related to the proposed IBA content and delivery procedure, and design the IBA accordingly.
3. Be mindful of target group 'cultures' and possible unwanted effects on relationships.
4. Avoid parachuting in training or an intervention shown to work elsewhere and expect it to be acceptable and effective in a different context.
5. Carry out careful, stepped development work and set up a sound infrastructure to facilitate IBA implementation in the long term as well as short term.

This section has looked at ideas about what *could* be done to facilitate the delivery of IBA (or versions of IBA) in wider contexts. The next section considers the ethical dilemmas which arise in advocating mainstreaming and prompts consideration of whether mainstreaming *should* be a policy aim.

Ethical dilemmas

Going beyond the practicalities of implementation and delivery of IBA, there are ethical issues that arise in widening IBA delivery into contexts outside clinical settings where there is at least some supportive evidence.

To answer the question of whether IBA *should* be mainstreamed, workshop participants returned to initial considerations of what exactly is IBA, what are the active ingredients, and what is most appropriate in different settings. If, as discussion at the workshop suggests, one of the definitions is that IBA is a relatively short

conversation that seeks to detect people whose drinking or lifestyle is risky or harmful to their health and motivate them to do something about it, then is that a valid goal, for workers in a non-health setting? A flexible model of IBA has not been tested and mainstreaming would rest on faith rather than science. Mainstreaming an intervention that lacks adequate evidence of transferability and effectiveness in different contexts presents ethical dilemmas. Will it do more harm than good?

The costs of mainstreaming – in terms of training, resource provision, allocation of staff time – may divert attention and resources from other concerns. Resources may be wasted if the 'wrong' professionals are targeted, for example:

there's an issue of are people in a position to actually use the training that they are receiving. A good example is the trial in (X hospital) A&E. They went in and trained 176 staff in how to deliver brief advice and at (Y hospital) down the road they trained 11 triage nurses. Six months later, not one in 176 people in X hospital were delivering any type of brief advice, they forgot all about it. In Y hospital, all 11 of those triage nurses were still doing it because they were in appropriate settings, they saw how it made sense to their work. They were there to do assessments so this fitted right in with what they naturally did ... what we have to do is find the people that are most appropriately set to deliver this. (workshop participant)

For some people, discussion of the pros and cons of drinking may reinforce reasons for harmful drinking patterns. As one participant said: 'The theory of behaviour change would suggest that advice alone might entrench the position of someone who is not ready for change'. This is compounded by the perceived stigma associated with admitting to, or seeking help for, problem drinking and the risk of false negatives that can result from reluctance to admit to a problem. The role of stigma in public health and its influence on public engagement in intervention and treatment – in relation to both alcohol and other substance use - merits further attention (Williamson et al., 2015).

Relationships between professionals and clients might be damaged by an ill-timed intervention or by one seen as inappropriate. In addition, rolling out the interventions to new settings might negatively impact on people's engagement with these environments. For instance, if people

are uncomfortable with their dentists asking them about their drinking, this may have repercussions for dental health care.

It is important to consider whether the ethical norms that people expect in a primary health setting can be honoured in other contexts. People need to believe that, when they go in to the pharmacy, the dentist, the youth club or workplace occupational health service, the same norms will be upheld. Issues of confidentiality and consent – taken somewhat for-granted in clinical settings – may present barriers to IBA delivery in wider settings. There is a burden of proof on those who advocate IBA in new contexts to assure the public that their concerns about confidentiality and consent will be respected. Settings such as criminal justice, education and social work are particularly problematic in that criminal justice involves loss of liberty, pupils in education are a captive target group, and people in receipt of social services are possibly under scrutiny. The extent to which consent can be considered free in such circumstances is questionable. There is, moreover, a greater power imbalance in some settings than in others. The workplace was mentioned as a particularly sensitive area for screening and intervention. Many employers now have alcohol policies and how this is interpreted by employees and management may incur unwanted effects:

.... What are employees meant to do when they are screened? Does that encourage people to be open and trust the environment in which they are now being asked about their drinking? Is that going to lead to false negatives and is that going to suggest to them that they don't have a problem? I understand that occupational health is bound by confidentiality, but occupational health teams are also employed by the employer; so that leads to quite a conflict of interest. (workshop participant)

Professionals, and workplace personnel, asked to identify drinking problems in their clients or workforce are often reluctant to do so because they feel there is a lack of appropriate support and services to manage the problems uncovered. If IBA is considered a helpful intervention, then ethically it should be made available to everyone who would benefit and, if a problem is identified, appropriate support or treatment should be available. This raises issues with the use of e-systems – increasingly seen as a good way to access some groups. Where

anonymity and confidentiality are assured, how can the individual receive appropriate feedback and further assistance if a need is identified? Is it ethical to deliver an intervention which relies solely on the recipient taking further action?

Finally, there is a need to consider the relative harms and benefits attendant on mandatory use of IBA in some settings compared to voluntary IBA and universal application to whole population groups compared to targeted intervention. For instance, the positive side to mandatory or universal screening is that it may reduce stigma. On the other hand, universal implementation of IBA would be costly and could be seen as a paternalistic intervention that contravenes personal liberties.

These ethical dilemmas may apply equally to interventions delivered in primary care and hospital settings, but they are more likely to arise in wider contexts where the professional or the recipient is unsure about the legitimacy of the intervention or its relevance to the particular context of the encounter.

Conclusions

There is a considerable appetite for rolling out IBA interventions into diverse contexts. The rationale behind advocacy of IBA is sound and the potential for early intervention to reduce harmful consumption patterns promises benefits to the individual and to society. Whether 'mainstreaming' should take place even in the absence of research evidence or whether further research evidence is needed, especially in new settings, before IBA can be implemented effectively on a wide scale, is an important question meriting attention in future debates.

There is little research evidence that 'classic' IBA approaches can be transferred successfully and effectively into a wider range of contexts. Issues of role legitimacy, role relevance and role support continue to pose difficulties for the delivery of IBA. Greater consideration of ethical issues is required to ensure that the benefits of 'roll-out' are greater than the potential harm that can arise from unintended consequences.

There is a considerable pool of practice-based knowledge and expertise regarding what works and what does not work in delivering IBA in different settings. This could be exploited to a far

greater extent to help adapt both the tools and the procedures for delivering IBA. It could inform a more careful developmental approach to translating IBA into more flexible formats adapted to particular contexts and settings. At the same time, the need for flexibility of approach has to be balanced with considerations of intervention fidelity. A clearer consensus on what is and is not to count as IBA might better inform both future development of IBA approaches and of monitoring systems.

It needs to be recognised that a developmental approach will take time and that political imperatives to justify expenditure by showing quick results are a constant counter pressure that must be resisted. This also means accepting that successful translation of the IBA idea into everyday contexts may demand not only reframing professional and public perceptions of what constitutes problem consumption but also reframing what is considered as IBA and how it should be delivered. Premature mainstreaming of IBA beyond traditional health settings is unlikely to result in effective, sustainable practice and would likely entail a waste of resources.

Key issues

Drawing on the available literature, on insights from our own IBA project and on discussion in the workshop, a number of key themes and issues emerged. These were:

1. the relevance of 'classic' IBA content and delivery in different service/ working settings
2. questions of intervention fidelity in reported IBA activity, along with consideration of the tension and boundaries between fidelity and the need for intervention adaptation
3. the need to build from the 'bottom up' to ensure that IBA can be delivered appropriately and effectively in different settings
4. the importance of preliminary work to ensure that organisational structures, managerial support, and staff awareness/understanding are in place prior to implementation
5. how to develop acceptable, practical systems whereby organisations/ agencies can monitor and sustain IBA delivery
6. the ethical issues raised by mainstreaming and whether the benefits outweigh the costs

7. consideration of whether further spread of IBA approaches into broader, non-health contexts should be dependent on the availability of better research evidence
8. resisting pressures from the wider political and policy environments which influence development and delivery of IBA interventions.

Notes

1. The project, The Role of IBA in non-medical settings is funded by Alcohol Research UK: grant reference number R2013/06.

2. The Maudsley Alcohol Pilot Project (MAPP: 1973-1977) examined ways of improving the response to alcohol problems, including the response by GPs. They found anxieties over *role legitimacy*: uncertainty as to whether addressing alcohol problems came within the GP's sphere of responsibility; *role adequacy*: not having the necessary knowledge and skills needed to respond to drinkers; *role support*: having insufficient sources of advice and support when unsure about how to manage, or refer on, people with alcohol problems. (See: Shaw et al., 1979).

3. The concept – or principle- of MECC has an interesting genesis. Yorkshire and Humber blazed a trail, particularly through the development of the Behaviour Change Competence Framework. At more or less the same time the West and East Midlands initiated action around Every Contact Counts (ECC). ECC and MECC are both ways of responding to issues raised in various official publications, all addressing 'silo' working, and putting the focus on prevention. In addition, the PH49 Behaviour Change Individual Approaches encouraged "all health and social care staff in direct contact with the general public to use a very brief intervention to motivate people to change behaviours that may damage their health". The Behaviour Change Competence Framework was launched in February 2010 and is being used by ten NHS trusts across Yorkshire and Humber and beyond.

4. Workplace Wellbeing Charter. Making well-being at work your business
[http://www.regionalplatform.org.uk/write/486_Workplace_Wellbeing_Introduction\[1\].pdf](http://www.regionalplatform.org.uk/write/486_Workplace_Wellbeing_Introduction[1].pdf) The Workplace Wellbeing Charter is a statement about the way in which employers run their business and support their workforce, demonstrated by adherence to a set of standards. The aims and objectives are to: introduce clear, easy to use well-being standards, improve well-being and reduce absenteeism, provide tools to measure and evaluate progress, identify and share good practice and real-life examples, show that workplace health and well-being is a worthwhile investment.

5. Down Your Drink is a 'Three Phase Approach' to help individuals take control of their drinking.
http://www.alcohollearningcentre.org.uk/_library/projects/files/Down_Your_Drink_promotional_booklet_159.pdf

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